ARMED FORCES INSTITUTE OF PATHOLOGY

ORAL HISTORY PROGRAM

SUBJECT: Dr. William R. Cowan

INTERVIEWER: Charles Stuart Kennedy

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[Note: This transcript was not edited by Dr. Cowan]

Q: Good morning, Dr. Cowan.

DR. COWAN: Good morning to you.

Q: Doctor, could you tell us when and where you were born and a bit about your family.

DR. COWAN: Certainly. I was born in Asheville, North Carolina. The date: 1932. My father was employed with the Southern Railroad there, and I spent all of my early life there. I was only away for short trips, until I graduated from high school in 1950. This was a period when no one traveled much, because it encompassed World War II and there were all kinds of restrictions on travel and so forth and such.

Q: Did people talk much about Tom Wolfe in those days?

DR. COWAN: Well, Tom Wolfe I have learned about since I left Asheville, because his book, "*You Can't Go Home Again,*" reflects a lot of the feeling about Tom and Asheville. In "*Look Homeward, Angel*," with the pseudonyms that he gave his characters, he only changed the first letter of the last names, so the people were rather readily identifiable. So he was not popular.

Q: In high school, were you getting any feel towards medicine at that point?

DR. COWAN: Well, I had at least one friend who was a physician. He had interested me in the field and also interested me in where I wound up going to school, at Wake Forest. He had been a graduate of that in his generation. And so that's what happened after high school, I left Asheville and got called to go down to Wake Forest. I had a plan there to either see if I could qualify and get into medical school, or my second love was probably chemistry at that time, so they paralleled each other as far as a college course was concerned.

Q: You graduated from Wake Forest in 1954. What was the main focus of your studies at Wake Forest?

DR. COWAN: Well, everything was very clear in those days. When you registered as a freshman, you were given a catalogue that said: "If

you'd like this degree, you must take these courses and complete them satisfactorily."

I actually left Wake Forest in '53. I had a combined degree, which encompassed three years of undergraduate study at Wake Forest, and then the fourth year at Bowman Gray became the completion for a Bachelor's of Science and Medicine.

Q: You went to Bowman Gray School of Medicine, in Winston Salem, where you got your doctor's degree in 1957. Could you talk a bit about the teaching and what you were doing there.

DR. COWAN: I thought at that time that the school was extremely good for a student, because the faculty all made their own living in taking care of patients. So they had a better, I think, physician-patient relationship than in many medical schools that I've visited since then, where the physicians were employed and paid by the school and not dependent on their patients for their income. In our situation, they were all dependent on the patients for their income. In return for their teaching, the school supplied them office space and support personnel. That all melded together to make an excellent atmosphere.

Our classes were extremely small by today's standards; we had 56 members in our class, so that everyone knew each other, and the faculty all knew each of us.

Probably the most interesting thing was a little question of reeducating the faculty. They had been quite spoiled up until our

class, because they had had a lot of World War II veterans that were older and more serious and more dedicated than, all of a sudden, these juniors coming in from college, with no broadening outside experiences. So it took them a couple of years to readjust to a normal medical-school class, but in the long run, it all turned out very well.

Q: Were they pointing you pretty much towards being what we'd call today family practitioners?

DR. COWAN: At that time, they were pointing you more towards just supplying the needs of western North Carolina. It worked out fairly well for most people to follow their own interests and find a portion. A lot of my classmates are family practitioners, but there is also a large number of specialists. A large number of those became, for instance, the first general surgeon in Williamsville, North Carolina, or something like that. So there wasn't the perception that we have today that there are too many specialists. At that time, we felt that it was probably the other way around, that there were too many general practitioners who were doing more than they should, because there was no one else to do it.

Q: I'm going under the assumption that we're talking about the mid-'50s in North Carolina, and the classes, one, were not integrated, and, two, probably had very few women.

DR. COWAN: Of the 56 in class, there were four women, and it was not integrated at all.

Q: Of the various aspects of medicine you tasted, did any whet your fancy at all?

DR. COWAN: Well, I'll have to admit, when I went through medical school, that after I passed sophomore pathology, I said, "I'm glad that's over with, because I'm never going to do that again."

We were a unique school. It was a small, 500-bed hospital. The way we were taught, we had patients, and we were expected to do a lot of reading and work them up really in depth. After getting close to graduation and applying for internships and so forth like this, I followed the advice of one of our staff members, who was from California. He said, "You know, you've had the experience here of having very, very few patients, which you were required to work up in extreme detail. The next thing, as far as your education, is you should go to a city hospital, where you have large numbers of patients that you have to take care of quickly and not the leisure that you've had here."

So I took his advice and went out to San Francisco for a year, and was at the City/County Hospital out there.

Q: Did you get married about this time?

DR. COWAN: Our honeymoon was the trip from Pennsylvania to San Francisco.

Q: Is your wife from North Carolina, also?

DR. COWAN: No, she is from eastern Pennsylvania.

We used to have a very unusual system at Bowman Gray that, when you were in your junior and senior year, one-fourth of the class was off each quarter of the year. There was a small hospital up in Pennsylvania that needed what we called externs, which were medical students kind of serving some of the role of interns for the charity cases in this hospital. Bowman Gray was, for several years, one of the few places that would supply their needs, because the people were available year round. Four or five of us would go up, spring, summer, fall, and winter.

And so, on one of those rotations, I met my wife's father, who was a family practitioner on the staff up there. Then I met my wife in '55, and we were married in June, after I graduated from medical school in '57. And we've been keeping company ever since then.

Q: You were an intern at the San Francisco City/County Hospital from 1957 to 1958. How did you find that? Was this a sea change?

DR. COWAN: Well, I think that was my first introduction to the idea that there are many different ways to do a task and come out with the

same end result. I think probably the most striking thing I've always thought about was that in surgery on the East Coast, where my experience was previously, all vessels were cut and tied and neatly secured. Then I went to surgery on the West Coast, and they'd already decided it was much quicker to cauterize the vessels. So that the first night that I came to surgery, I was awake all night waiting to see if my patient was going to bleed to death or not. But I soon learned, like I said, that there is more than one way to achieve an end goal.

Q: Was your time as an intern sort of the standard, doing a whole series of things?

DR. COWAN: That's what my internship was, with 12 different rotations over the year I was there. I purposely took a rotating internship, because I had gone to medical school with the idea of becoming a family practitioner, and I decided, as I went along, that I was less and less suited for doing that, but I decided I'd give it one more try, under different circumstances, as an intern, and rotate through general medicine again. About halfway through that year, I decided that perhaps I'd make a better pathologist than I would a family practitioner.

Q: Could we go into this a little. I'm sure you've thought about this. What's the difference between being a pathologist and a general practitioner? A young doctor's up there looking at this thing. What

are some of the decisions and reasoning behind moving to one or the other?

DR. COWAN: The two kind of mix, as far as I'm concerned. I enjoyed being the problem solver for the other physician, who didn't have the time because he was too busy seeing patients. I could take his problems and work them out and present a solution to him quickly.

I also developed sort of an intolerance for the people that were sick, but they were sick in a non-physical way. They thought they were sick, but they were really not sick. They were very demanding on your time, and I became very impatient with these and decided I did not want to do this for the rest of my life. I was willing to spend all the time in the world if there was something that I could actively do to make a patient well. But these people that thought they were sick and weren't and you could never make well, I just could not think of doing that every day for the rest of my life.

Q: What sort of exposure had you been getting? You said you took sophomore pathology and you were glad it was over. How did you get back into pathology?

DR. COWAN: Well, you have continuing exposure to it as it applies to medicine, instead of as a didactic course. All the laboratory tests, the support of pathology to the surgeon, telling him what tumor he's taken out, or other advice to that, and after the autopsy, and various

other aspects of the practice of pathology began to interest me, rather than the didactics of it, which was a very hard course. For most medical students, it's almost like learning a foreign language. You, all of a sudden, learn about all the diseases and all the agents that cause the diseases, and it can be just very intense.

Q: By the way, could you comment on being an intern. As a non-medical person, I've always been a little bit concerned about going into a hospital where people are being worked 36-hours-a-day. I assume you went through that.

DR. COWAN: Well, this is another example that youth is not wasted on the young. I think all of us, when we were young, very frequently could drive across country all night, come in, take a shower, go to work, and not think anything about it. As you get a little older, you no longer can do that. It's the same thing with an intern, that the internship comes at a point in life when it doesn't bother you.

I think some places were a little bit abusive, but perhaps, like many things in the American environment, they've gone too far with the swing of the pendulum in the other direction and taken too much away from them and reduced the amount of responsibility they carry. Which, of course, is what the intern is doing. He's a physician that is practicing under the supervision of a trained physician to learn to be independent and take care of patients. And if he doesn't have that opportunity under supervision, then, all of a sudden, he is turned

loose and... I think that we've lost a lot of ground in the restrictions that have been placed on him in the training program.

Q: From 1958 to 1962, you went back to Bowman Gray. Why did you go back there and what were you doing?

DR. COWAN: I had looked at some pathology training programs out on the West Coast and decided that I didn't want to stay out there any longer and I didn't like the programs, so I called Dr. Moorehead, who was chairman back at Bowman Gray at the time. Actually, instead of all the lengthy applications that usually transpire in acquiring a position like this, I called him up on the phone one day. I was already in the Air Force, and I asked him if he could find a place for me if I could convince the Air Force to send me there for four years. So we sort of made an agreement over the phone that day. And so then I had to get busy with the Air Force and have them assign me there.

Q: Could you talk about getting into the Air Force. How did that work?

DR. COWAN: I came into the Air Force as an intern, right after I graduated from medical school. That was one of the ways I could afford to get married. At that time, the Air Force would sponsor you for a year of training; in return, you spent two years on active duty as a physician. In those days, there was still the two-year obligation,

which would have meant that I stayed in the Air Force, after I finished my internship, for four years instead of two years. So, having decided that I wanted to go into pathology, I could combine all of this and be doing what I wanted to be doing, instead of spending my time as a general medical officer. So that seemed good. It came out so that, after I finished my training, I had five years' obligation to spend with the Air Force.

So I went from residency down to Fort Worth, Texas, to start paying this time back. With the time there and one year up at Scott Air Force Base, by the time that I was eligible to get out, I decided that I was enjoying the Air Force. My assignments were good, and they were treating me fairly well. The opportunity came up at that time to go to Wiesbaden, where I stayed five years. By that time, I was sort of over the hill as a career Air Force officer.

Q: I want to go back a bit.

DR. COWAN: Sure.

Q: You left Bowman Gray in 1962, and you went first to Texas, is that right?

DR. COWAN: Right.

Q: You were chief of laboratory services at Carswell, Texas.

DR. COWAN: Well, Carswell is the Air Force Base. It's in Fort Worth, Texas.

Q: You were there from '62 to '67.

DR. COWAN: Right.

Q: When you say "laboratory services," was this basically pathology?

DR. COWAN: Pathology. The military has always called pathology "laboratory services," or it did at that time.

Q: What type of work were you doing?

DR. COWAN: I was doing general pathology. It was kind of an experience for me. I'd been up to speak with Dr. Townsend, who did the assignments at that time, and we had discussed the places that I would like to go. He had sent me home to write him a letter on why I should go to all these places. So I did. Then my orders came down to me, and I turned to my wife and said, "Have you ever heard of Carswell Air Force Base? That wasn't even on the list."

As it turned out, it was an excellent assignment. I was the first fully trained pathologist in a 250-bed hospital. So it was a big step, and there were a lot of growing pains to it.

Dr. John Anderhar was my consultant in downtown Fort Worth. I used to always have sort of a standing appointment with Andy every Thursday, to take down the surgical specimens that I'd processed and I wasn't quite happy with the conclusion I'd come to, so I wanted to show them to another, more experienced person before the final report went out. So we had these standing, weekly sessions for doing that, just like a conference back at the school.

Q: Did you have any contact at this point with the AFIP?

DR. COWAN: At the time, things were much more rigid than they have been since then, so that only if you were designated a histopathology center could you be a direct contributor to the AFIP. At that time, I did not have my boards in pathology, so that was another one of the incentives, that I had to have my boards before I could be a histopathology center, and not have to send anything that I wanted to send to the AFIP to Lackland AFB and let them send it up, which the fellows down at Lackland and I used to always joke about, because they had all finished their residencies and they were at exactly the same level of experience as any other. And so it was sort of a joke when I sent it down for an expert opinion, because they just sent it on up. Because if I were having trouble with it, they were usually having trouble as well.

Q: You mentioned that you'd talked to a Frank Townsend.

DR. COWAN: He was the director at the AFIP at the time, and also a consultant for the Air Force surgeon general, later. At that time, I did not think that he was a very kind person. But as I wound up having the same job several years later, I could appreciate his point of view.

Q: In the Air Force, did you find that, once you were a pathologist, you stayed a pathologist? How did they deal with you?

DR. COWAN: I think a lot of people are sort of under the misconception that, as you get promoted and become more senior, you always become an administrator instead of staying a physician. And I did not find that true at all. In fact, my experience was that those that statement applied to wanted to get away from practicing medicine, and administration was a way to do it. Up through full colonel, everywhere that I was ever associated, you could stay full time practicing medicine and have relatively little administrative responsibility. You have the committees, like tissue and transfusion and equipment and everything else, just like you have in the civilian world, but I think that was done.

Q: You went then to Scott Air Force Base, from '67 to '68. What were you doing there?

DR. COWAN: Well, I was chairman of pathology, and also at this time I had been to flight surgeon's school, so I was also a flight surgeon. For three half... I was chairman of pathology, I was director of the flight surgeon's office, and, as director of the flight surgeon's office, I also had the responsibility for what we called the RON ward. This is where the patients are being transported by air-evack from overseas. They would remain overnight (RON) in our facility, and then be put into the domestic air-evack system, to be taken to a hospital closer to their home or whatever was appropriate.

Q: When you say "flight surgeon," what does that mean, actually?

DR. COWAN: They're physicians who take care of the flying personnel and their health care needs. There was, at that time, a three-month course down in San Antonio. You have an extension of your normal medical-school physiology, how various gases affect the body at low altitude and high altitude, and various other physical problems that occur in the flying environment, which makes the health care of pilots and people who are responsible for the aircraft a little bit different from what you would have with your normal patients. For instance, certain medications, you don't want to have your pilot get a little drowsy and sleepy while he's holding the yoke.

Q: Well, then off to Germany, where you were in Wiesbaden from '68 to '73. The Air Force hospital in Wiesbaden was really the major Air Force hospital in Germany, wasn't it?

DR. COWAN: Right. Actually, it was the referral hospital for all of Europe, except for England, where they had a rather large facility over at Lakenheath. But we basically were the point of referral for all of Spain, Portugal, North Africa, and extending east to Pakistan.

Q: I know, my wife was air-evacked from the American Embassy in Belgrade, Yugoslavia, to Wiesbaden, a couple of years before you arrived there. What were you doing there?

DR. COWAN: Well, I was chairman of pathology there at the hospital.

Q: Did you find that dealing with places such as North Africa and Pakistan brought in new problems because of conditions in those countries?

DR. COWAN: That was when I first appreciated the extent of training that we'd been given in medical school. We'd learned about unusual diseases like Tay-Lazar, and thought, "That's worthless information; I'll never see a patient that has that." So, in Wiesbaden, this was the first time that some of those things that I had learned and barely remembered from medical school started to come in focus again. We got

several cases of leishmaniasis from down around the Mediterranean coast and Greece and Turkey, where it's sort of endemic.

Q: By the way, were you using the AFIP much there?

DR. COWAN: Yes, we used them quite a bit. They were our consultants, so that if we had difficulty in reaching a diagnosis that we were absolutely comfortable with, we could send the case in for a consultation.

We were required (and because we were overseas really tried to abide by the requirement pretty religiously) to forward to the AFIP all of our autopsies and all of the cases that we had that were diagnosed as malignant on a patient. And this was really very important, because when a base closes down, sometimes the material that is stored there may or may not get transferred, and occasionally gets lost. And this would be detrimental to the patient's care if that material were lost, and they were transferred somewhere else, and somebody would like to review that material as far as their health care was concerned. So that's what drove these regulations for sending the rare and unusual, the malignancies, and anything else that might be of administrative value. Somebody might have a claim against the government, so they'd like to have the pathology on file in a central place. And so when that patient came back to the States and their treatment was taken over at another facility, then they could turn to the AFIP and ask for them to take that material out of storage and continue that patient's care.

Q: Then, in 1973, you were assigned to the AFIP as the deputy director, where you served in that position until 1980. This was the first time you served at the AFIP.

DR. COWAN: That's right. I had been trying to avoid it. I'd always jokingly said that I couldn't afford living in the Washington area until I was a full colonel on flying status. And even though I was a full colonel on flying status, I still wasn't sure that I could afford to live in Washington!

Q: You arrived here in '73, which was a rather turbulent time, I gather from my other interviews. This was the time when the AFIP had some problems, particularly at the top in relations and all. You're the new boy on the block, where you always have a different view than if you sort of come up through the system and accept it. What was your impression of the AFIP and what you were doing and how it was run?

DR. COWAN: My impression, when I first got here, and I was the Air Force deputy, replacing Dr. Morrissey, who had been the Air Force director prior to my coming... And I'll preface this right here, that I really wasn't supposed to come to the AFIP. Dr. Morrissey, who was doing the assignments at that time, and I had worked out an agreement that it was time for me to come back to the States, and it was also time for someone to take his place, and so he'd asked me was I interested, and I said, "Well, I'd really rather stay in a hospital."

The agreement that Dr. Morrissey and I made was that Dr. Schwam, out at Andrews, was going to move over here to the AFIP, and I was going to take his position out at the hospital at Andrews, which suited everybody fine. Several months went along, and Dr. Morrissey called me one morning in my office over in Wiesbaden, and he said, "Do you remember that deal that we struck?"

I said, "Yes."

He said, "Well, it's not going to work. It got out of my hands and got downtown, and some people started fiddling with it. And so you're coming here to take my place, and Harry is staying where he is."

So, at that point, I said, "Well, I haven't been there." I've sort of always been of the philosophy that, to visit a place, the fact that you haven't been there is enough excuse in the first place. So that if you've been there and you like it, it's a good enough excuse to go back again. So I came in with an open mind.

I found a lot of unrest when I first got here, because Dr. Morrissey and the senior civilians had not gotten along well together at all. It had made him unhappy and made them unhappy.

Also, you have to reach back even four to five years farther than that, in that Dr. Leaper had had the position as deputy and had been asked to leave by Dr. Smith. And the surgeon general's office opted, even though there was no real reason as far as his competency was concerned, to solve the personnel conflict by sending Dr. Leaper down to Wilford Hall at Lackland, in San Antonio, Texas, and moving Dr.

Morrissey up here. So Dr. Morrissey was not really too happy when he came in, and then moved up the next year as director.

There was actually an effort at the time, on the part of the Army deputy, Dr. Hansen, and some other Army members, because Dr. Morrissey had been here such a short period of time, to change the rotation, which was normally Navy, Air Force, Army, Navy, and so forth, between the three services. They said that he couldn't have enough experience as a deputy, and that the Air Force's turn should be skipped at that point. Well, it turned out it wasn't, as you might tell by the fact that he was deputy. But that created a little bit of animosity.

And then also it created a little bit of animosity after Dr. Morrissey had left, in that the surgeon general changed from Dr. Jennings to Dr. Taylor, who was an archenemy of Jim Hansen. And probably, if Dr. Taylor had picked a person to be director of the AFIP, Dr. Hansen would have been at the bottom of his list. So they had quite a bit of friction there.

Dr. Taylor was a very strong-willed person, and he had decided that many things were being done at the AFIP at that time that maybe shouldn't be done; maybe they were illegal, extending beyond the Army's mission at the AFIP. So he made life very rough on the three of us, Dr. Hansen, Dr. Schrodder, and myself, at that time.

I was reminded one day that there was an Air Force general by the name of Patterson who had been a friend of the AFIP forever, it seemed like. I remember reading the AFIP history, and all of a sudden he pops up in there, as a major in the Air Force, as chairman of a major

committee back somewhere in the '50s that was quite beneficial to us. And he continued to be beneficial even when I was here and when we were having this hard time with General Taylor.

At that period, our board of governors was only the three surgeons general. It was not expanded, as it is now, to the other services and the VA. It was just those three members. We were taking our blows from General Taylor at one of these board of governors' meetings, and General Patterson looked at him and said, "Dick, I think they have some problems out there. But I think they've got an awful lot of problems that are over on this side of the table." That sort of attracted his attention, and he was quite helpful with us then to get some of the things turned around.

We had already turned around and solved a bunch of the problems. And then we moved on to the next step, which was legislative, with the Kennedy legislation.

Q: This was Senator Edward Kennedy of Massachusetts.

DR. COWAN: That's correct. In 1976, I guess with a little influence from some of our senior civilian employees here at the AFIP, a bug was planted in his ear. That year, he had placed a rider on the Department of Defense Appropriation Act that established the AFIP as an entity, and recognized the fact that if we didn't exist and do for the civilian world what we were doing, that at great expense, the NIH would probably have to set up a new entity to duplicate what we were doing very well

for both the military and the civilian. It set up the Registry of Pathology, set up a new board of governors, and actually placed the function of the board of governors under the Department of Defense instead of under the Department of the Army.

These were all great big things, which basically said that everything that you've been doing that people have criticized you for is now okay and legal. Well, even though we had it in black and white, Dr. Cowart and I were a little reluctant to push it too far.

Q: I'd like to go back and we'll go over this ground, because I think it's very important for an institutional history. Dr. Morrissey left here early and was annoyed when he left and said there were a lot of problems with the Institute. Could you talk a bit about how he saw it, and how maybe the system saw him and the conflict there.

DR. COWAN: Well, I think you have to look at Dr. Morrissey's background. He had always been at a hospital, in a pathology function. And the atmosphere here was certainly not that of a hospital, although an active health-care facility. I think that there were some things that needed to be improved. In fact, some that still existed when I got here that needed to be improved were rapid response to a contributive consultation, and some other functions, and some projects that were going on that just didn't seem to have any purpose to them. He eliminated some of them and made some enemies along the line. And then I think his time was just rather frustrating. I think this

conflict between the Army and Air Force that preceded his taking the position as director also created some camps within the Institute that favored Dr. Hansen versus Dr. Morrissey.

Q: Dr. Hansen being an Army doctor.

DR. COWAN: Army doctor and deputy under Dr. Morrissey, and director after Dr. Morrissey left.

Q: I have the feeling that when Dr. Morrissey came, he found the AFIP where each of the various divisions were sort of responding at their own pace. They were like little petty kingdoms, almost.

DR. COWAN: Right.

Q: Under very renowned people, but some responded quickly, some didn't, and they didn't respond to direction from above with enthusiasm.

DR. COWAN: This certainly happens many places where you have a mixture of civilian and military, and you have a military director whose tenure is only four years, and you have a number of civilians that have been there forever, and they say, "Well, we can outwait one more guy, until he gets out and somebody takes his place, and then we'll work on the next guy."

Q: How about the response time, because there's the problem of people out there waiting to do something and to get an answer. At the same time, a scientist wants to have plenty of time to contemplate and to examine and to reexamine a subject, and there's this conflict between turnaround times when people send in requests. Did you find this a problem when you were there?

DR. COWAN: Yes, I did. We had several problems. One of the difficulties was getting a case accessioned and into the hands of the physicians so a report could be generated. I first started working on the accession system as it existed, and decided that it could not be improved, that the only way to do was do away with it and put another one in its place, which we did. It took several years, but we eventually did.

Q: What was the difference in approach?

DR. COWAN: Well, that's when we computerized the accession system, and set revised goals for getting the cases in the hands of the physicians. Also, there were certain times that cases would come in that had incomplete material, and sometimes the clerical people made judgments that this was incomplete so it should not be processed until everything was complete. Well, this correspondence could delay something important that required a length of time. So we shifted that responsibility from the clerical people to the physicians in charge of

the department, or their delegates. So those cases that fell in that category that they were incomplete when they were submitted were placed in a given spot downstairs, in the appropriate department box, and it was up to a member of that staff to come down and decide whether that should be delayed until the complete information was there, or could we send out a preliminary report that would be beneficial for patient care, or was all that material necessary and could it be processed without having every little requirement met. So that combination of the computer, to more quickly accession things, and placing different responsibilities, I think, speeded up things quite a bit. When I was there, it was not speeded up as it is now, with the recent changes in consultation services. And a more active role of the American Registry has been helping the AFIP government staff in getting the reports out.

Q: Well, Col. Hansen was having his problems from the surgeon general. How did that affect his being director of the AFIP?

DR. COWAN: As I saw it, and I may have just been mistaken because that was my first real exposure to the Army, it seemed that, as compared to the folklore of previous Army commands, funding and resources were harder to come by, so that it was sort of a period that we were more defending ourself against being put out of business, rather than moving ahead.

Q: You mentioned that somebody got the ear of Senator Kennedy on this Act of 1976. Were members of the AFIP, yourself included, sort of dropping hints to the senator's staff to say what you'd like to have?

DR. COWAN: We happened to be lucky at that time in that one of Senator Kennedy's aides was a former staff person from the AFIP, a scientist who at that time was over at the University of Maryland. He was on a year's sabbatical as Senator Kennedy's aide, so that he sort of lined this thing up. This was, I guess, my first exposure to really in depth political maneuvering, because it was attached to the DOD appropriation bill that year, and, of course, unless it were accepted, then there was a holdup of the whole bill, which no one really felt was appropriate for the piddling little part that the AFIP added to it. In fact, the only thing it added to it was the authorizations. The thing it didn't do was take care of our funding. It was a bill in word only. But it did serve to establish the Institute, and it established its mission, which had never really been outlined before. It just kind of grew like Topsy.

You know, it started in the 1860s as the Army Medical Museum. And I think it started for a very, very good reason. At that time, with the Union Army, day-by-day camp life was killing about as many people as the battlefield. And so the first curator of the museum was directed by the surgeon general at that time, after they had decided a course of treatment and the appropriate thing to do medically, to collect specimens and also to conduct educational courses for his field

surgeons to try to improve the morbidity and mortality of war wounds as well as camp life. And so it was as a museum that it really started.

It continued that way for many years, and as time went on, gradually accumulated added responsibility. It became the custodian of the surgeon general's library in the late 1870s or so. At that time, the surgeon general's library was considered to be the greatest collection of medical literature in the whole United States. It was greater than any of the medical schools or anything else like this. And so that is how the old Army Museum, which used to rest down on the Mall by the Smithsonian, came into being, that it was to house the museum and also the surgeon general's library. It was because of that library that we had the backing of the AMA and everything else to get that building built, which was in the late 1880s. It stayed there until the mid-'60s, when it was torn down to make room for the Hirshhorn Museum. The museum at that time was added to this building out here. But between '55 and '65, the Institute operated by sides.

As you went along, this surgeon general's library became the nidus for the National Library of Medicine. And the Walter Reed Army Institute of Research had its beginnings as what was called the Army Medical School, which was part of the AFIP. It was primarily an intensive course in tropical medicine, and operated for many years under the aegis of the medical museum, until it became independent and moved out here to the campus of the Institute of Research. So it's been kind of interesting, some of the children of the old museum,

including the AFIP, have outgrown the original museum. But that was the beginning of the whole thing.

To kind of round out that picture, it was only post-World War II that it was briefly the Army Institute of Pathology, with roughly the same role, but it was strictly Army at that time. But that only lasted about three years. Then the Air Force was created, and the Department of Defense was created in 1949. So the decision at that time was to put in representatives of all three military services, making the Institute tri-service, and rename it the Armed Forces Institute of Pathology.

Q: The '76 Act kept the AFIP from having surgeons general look at it and say, "What are you getting all these civilian referrals for?"

DR. COWAN: That's one of the things.

Q: This is always, I suppose, a point of contention. And if you're looking around for cutting, you say, "Well, what are you doing here? What's the military purpose?" Was this part of the conflict that this Act helped solve?

DR. COWAN: It did help solve it. The problem came about, reaching back into the 1930s, when the American Registry of Pathology was first established. And I think it was the ophthalmologists that were the first group of specialists in the country to back this idea, both with

their money and with pressure on their members, of sending specimens to the registry there, with the very well-founded idea that, with dealing with changing times in medicine, if you've got 100 people scattered around the country, and if each one of them has one example of a rare and unusual tumor, you can't make any judgment or conclusion or anything else like this, so why don't we find a place where we can have those 100 people send that one case that they have, so that all 100 will be there, and then somebody can put them together and analyze them and come up with some educational courses and recommendations for improved treatment. Well, that's how we first got into the civilian business.

It was good for us as far as our education, research, and training programs were concerned to get material from the civilian population that the military population, composed mostly of men between the ages of 20 and 40, would not be contributing. And so that was also a reason for the registries.

By the time that I got here, we had moved up to something like 60,000 cases a year--30,000 were civilian, 30,000 were from the military and VA, so that almost half our workload was in the civilian area.

In my estimation, the reason it was so valuable as a national resource was that, across the country, probably a real trained pathologist could take care of 90 percent of all the specimens that came across his desk, and make appropriate diagnoses and give proper care to that patient. We didn't get any of those. There was perhaps

another five percent that he knew what it was, but he didn't feel comfortable with it and he'd rather have a second opinion. We got a lot of those. Then the other five percent was a very rare and unusual thing that he perhaps had never seen before and did not feel comfortable with at all. Well, we also got those specimens for an opinion. Once those cases arrived at the Institute, just because our people in the very specialty departments saw those regularly, they were able to take care of maybe 60 percent of those without any difficulty, without doing anything unusual, just because they saw so much of the rare and unusual. And then, because of special equipment that we had here, like EM and various other special tools...

Q: EM means...

DR. COWAN: Electron microscopy. We were able to do other studies that the civilian contributors couldn't do, and take care of perhaps another 30 percent. And so the remaining 10 percent, fortunately for the people across the country as a whole, is a very small percentage of the overall picture. Those are the ones, that last 10 percent, that we used to kind of joke about, that we could send them to 12 different experts and get 13 emphatically different opinions.

Q: What was your particular role, because there were, what, two deputy directors?

DR. COWAN: Two deputies.

Q: Did each of you specialize, and who was the other deputy while you were there?

DR. COWAN: When I first started, Jim Hansen, from the Army, had just moved up to director, and Bill Schrodder, from the Navy, was the other deputy. When you have a director from one service, you have two deputies, one from each of the other services.

As time went on, Dr. Schrodder opted not to stay. Whether it was his choice or someone else's, maybe his choice was not... He left after I'd been here a couple of years. Then, Dr. Cowart came in as the Navy deputy, and after Dr. Hansen left at the end of three years, he became the director. At that point, Dr. Dwyer came in. Dr. Dwyer was a very energetic and interesting person. He had been selected for brigadier general, but they didn't have a job for him, so they made him deputy for one or two years. And then the Army deputy, Dr. Stansford, took his place. I think those were the only changes at that time.

When I moved up from deputy to director, I had two new deputies assigned, Dr. Karnei and Dr. Zuck. Dr. Karnei was the Navy, and he later stayed to be director. Dr. Zuck decided he didn't want to wait around as long as needed to be for the Army's turn to come up next. Also, they gave him a position at the Army Institute of Research out at the Presidio in San Francisco. It was at a time in his life when he wanted his own organization, so it all worked out well for all of us. Dr. McMeekin at that time took Dr. Zuck's place.

Q: In other interviews, I've had the feeling that Dr. Zuck was a very lively person, with lots of ideas, and sort of charged around here.

DR. COWAN: Well, yes, I would describe him that way. He was a very bright person. Probably it was to his benefit and to the Army's benefit and to everybody else's that they offered him this job, because Tom had severe trouble with his neck, and he had difficulty at that time finding a suitable microscope in order to be able to do anatomic pathology. He was extremely knowledgeable and good in anatomical pathology, but his neck would hurt him if he did it very long. So he had sort of shifted over and most of his function and interest was in clinical pathology, especially blood banks. He went on to become the president of the American Association of Blood Banks and was the editor of their *Journal of Transfusion* for a number of years. After he retired from out at the Presidio, he went to Cincinnati, where he is now the director of the blood bank at the university up there. So that was his forte more than the anatomical path., which had been most of the rest of it.

Q: As a deputy director, did you have a particular field within the AFIP that you were responsible for on the administrative side? And did you have a research side, too?

DR. COWAN: Right. The way it was set up, it was at the director's discretion, but he would assign a deputy to primary oversight of several areas. I started out with the museum and medical illustration service, which included all the exhibits and the print shop.

I became rather interested in the print shop. The major function down there was printing the *Atlas of Tumor Pathology*, more commonly called the fascicles. Dr. Permenger was editor at that time, and he was to retire somewhere around '75 or '76. Dr. Hartmann became the editor, and at that time, Dr. Hansen said I was going to become the co-editor. I didn't function as an editor usually does in getting books ready for printing. I was primarily responsible for making sure, on a day-by-day basis, when all the photographs and all the texts came of the press, that the quality of the pictures was excellent and that they illustrated what the legend said they did. So that was my co-editorship of the fascicles, which was quite demanding and quite a bit of fun.

We worked with the original UAREP at that time. And that was another thing that changed around a little bit. It had been set up with the primary function of publishing the fascicles, under Dr. Blumberg's regime, and also of sponsoring grants. It was made up of representatives of ten major medical schools, and they met quarterly for some permit grants and also to pick the authors for the fascicles. They also funded from their revenues the preparation of the manuscripts for publication. Their role changed considerably with the '76

legislation and the creation of the American Registry of Pathology as an entity instead of a collection of registries.

Q: You mentioned one of your responsibilities, besides the illustrations, was the museum. It was during this period that the museum was almost moribund, wasn't it?

DR. COWAN: Yes, in fact, when I got here, several previous museum curators had been senior veterinary officers down there, and they never seemed to be anything but custodians. So, along about this period, it was decided that more attention should be paid to it, and we were able to secure a physician interested in being the curator. It did expand the activities, although we had a setback for a couple of years and were again, like you say, totally inactive. Their space was given to the Military Medical School over at Bethesda for a period of either two or three years, and we put all the artifacts from the museum in storage and gave them the physical space to get their first few classes started, while the buildings were being constructed over at Bethesda to finish the school. So the museum during that period was totally inactive.

Q: Stretching over the time, up to the time when you retired as director in '84, did the role of the museum change at all? What was the rationale for the museum, and did that change?

DR. COWAN: I think it did. And I think that we felt that some of the interest that the museum had downtown was rejuvenated, in that we started having an increased number of visitors. As we changed some of our educational programs and exhibits and rotated them more often, we found that we had more visitors out here. We were not quite sure, looking back at the record for the number of visitors that we had downtown, whether they were coming in to see the museum, or whether they were coming in to get out of the rain or use the restroom or what have you.

Q: In some of my earlier interviews, people said one of the great demands for the museum was the fact that it had probably the best set of restrooms on the Mall, in that period.

DR. COWAN: So we were never able to discern exactly what portion of that number were there for that exact reason and how many of them came to see the museum.

But we did increase up here. The medical curator, I think, did make a difference in the direction of the exhibits and displays, and they become more educational and less just impact from the deformities or something like that.

Q: Training has always been a very important element of the AFIP. In this rather long period that you were here, from '73 until '84, was there any shift in emphasis in the way things were done?

DR. COWAN: Yes, I think we had quite an increase in the number of short courses that we did. At one point early when I was the director, we had 30 short courses, for a week apiece, and on those 30 courses, we had 30,000 man-days of education supplied. This was done at a time during the history of medicine as a whole in the country when certain organizations were requiring physicians to have so many hours of continuing medical education in order to renew their credentials.

Of course, the educational mission had always been a part of the museum. In fact, the specimens contributed to the museum, as examples of pathology, were where the material for the education had always come from. So that was expanded as it shifted from the museum to the pathology function, and the number of museum specimens dropped off, but the ones sent in for pathology rapidly increased.

Q: Somebody who has been sitting around as deputy and all, you're always sitting there saying, "Oh, boy, when I'm in charge, these are some goals I'd like to do." Did you have any particular goals in mind when you took over as director in 1980?

DR. COWAN: Well, I wanted to work on the turnaround time. I felt that probably a week was a reasonable time to put an answer back in the hands of contributors. So I continued along that line.

And then probably one of the biggest changes that happened soon after I became director, and it was with a lot of help from Dr. Mendez,

who was deputy surgeon general at that time, was that we had a couple of sessions in participatory management, in which we tried to get a lot of our senior civilians out of their own little departments and into being part of the Institute. I thought a saw a striking change along that line during the early part of my directorship, that all of a sudden people were shifting and taking a role as part of the Institute, instead of their own department, and were actually working together to share resources better. Of course, space is one of the biggest resources you can have. The number of joint projects increased.

Q: By the time you became director, the new AFIP, under the '76 Act, had been there for four years. How did you find the relationship with the surgeon general?

DR. COWAN: By this time, General Taylor had moved along, and when I came in, we had shifted to General Pixley, who was much easier to work with and actually had some things that he wanted us to do.

There was at that time an interest in a program the Army set up called the "Over 40" program. They weren't quite sure whether people in the Army who were over 40 were ready to go to war without having a heart attack on the way. So they set up this training program for which they needed someplace to handle the data. Well, we needed a new computer system at that time. So we put a proposal to General Pixley that he could kill two birds with one stone, that he could find a place

for his data bank and upgrade our computer system at the same time, which he finally agreed to.

That was a real trial for us. We'd had an IBM 360, which we had upgraded from a 360.40 to a 360.60. But it was a big central processing unit and not the type of computer support we had here.

When we changed and went to the Hewlett Packard, the original change was meant to encompass only the accessioning area. But, as the planning went along, the surgeon general's office said, "We have a little more money, wouldn't you like to put the whole Institute on a computer system, instead of just accessioning?"

Well, all of us had been around long enough in the military to know that when somebody offers you some money, you take it, because if you wait until you're ready to ask for it, it may not be there.

The accessioning part of it went fairly smoothly, but we had almost a revolt on our hands from the rest of the clerical people, saying that we'd pushed this on them too quickly.

It was very pleasant for me to come back a couple of years after I had left (looking back at the amount of friction we had created) and find people who were using the system and didn't know how they ever got along without it.

Q: The AFIP, from the accounts I've heard here, is an organization like almost any other organization: it tends to resist change at the bottom, but when the changes come, they're accepted and things do work better. The AFIP is supposed to be on the leading edge of research as

far as specimens coming in and all, and it's a national repository. Were you getting the advanced equipment necessary? How did you feel about it?

DR. COWAN: I went through a period when people were complaining. And perhaps we were not getting as much money as we had in years previously. But, repeatedly, when they were poked with the question of what do you really want that you don't have, I got nothing to go downtown and say we really need this.

Q: When the Carter administration came in, the military was in disfavor; anti-Vietnam and all this. And then, in 1981, the Reagan administration came in with a new burst of national good feeling, and the military was included in that. Did you feel any change in either your mission or the support you were getting?

DR. COWAN: When I got here in '73, most of the Vietnam pressure had phased away. The thing that I kept getting, and probably the people who had been around that long would say so today, was that the heyday of the Institute was probably in General Blumberg's period of being director, which was during the Korean War. Of course, the draft was still in effect then. The people who were animal handlers up in the zoo on the 5th floor had Ph.D.s in biology, and you'd have an animal handler being the second author on a paper with one of the senior staff people here during that period. Also, there were increased numbers of physicians drafted during that period, and quite a number of them were

pathologists and wound up here and were contributors at that time. The monies were also fairly plentiful. So that, all in all, it was probably one of the best periods. And General Blumberg, or Joe, as everybody called him, was probably one of the most personable people that I've ever known. I think that probably one of the high points in the Institute was during his directorship.

Q: Did you see any change, in the change of administration between Carter and Reagan, as far as support went?

DR. COWAN: I would say that probably the biggest thing, during Carter, was that there was a long period where there was not an assistant secretary of defense to help us there. The position was being filled temporarily by Vern McKenzie, who was an administrator who served as a physician, and he was not too generous. Once we transitioned back into a physician...I'm trying to think who it was who took that position. But it's hard to say whether that made the difference, or whether it was because the '76 legislation starting making the difference.

Q: But, as director, this is where you looked for the ultimate guidance, to the assistant secretary for health affairs?

DR. COWAN: Correct.

Q: He was your boss, in a way.

DR. COWAN: Unfortunately, we had two bosses, but they were both pretty good during the period that I was here. With the change of the board of governors, you had the assistant secretary of defense for health affairs as the chairman of that. And just to take a quick look back on it, I had mentioned earlier, the previous board used to be just those three surgeons general. But the new board had the assistant secretary of health as the chairman, the three surgeons general, and also the Public Health Service and VA and one extra director added to make up the new board. They met quarterly to basically establish our policies, what we were going to do. And then it fell back to the Army surgeon general and his office to find out how to pay for it. And sometimes there was just a little bit of friction. The Army surgeon general I can understand not taking kindly to somebody else deciding how to spend his money.

Q: How did you find the new American Registry of Pathology, which was part of the '76 Act, which was designed really to give you (it's my understanding; correct me if I'm wrong) an outside entity which could both collect money and supply funds and do things really sort of the outreach program? How did it work?

DR. COWAN: I don't think that facet of it really came into being in any magnitude until after I left. The initial things that we benefitted from were bringing on two or three individuals under the

Distinguished Scientist provision. Also, in the Atlas of Tumor Pathology business, instead of going through the GPO, we sort of became a branch of the GPO as far as that function was concerned, the only branch as far as that function.

Q: You retired in 1984.

DR. COWAN: Correct.

Q: What did you do?

DR. COWAN: After I left?

Q: Yes.

DR. COWAN: Well, I was first going down to San Antonio to get a job that kind of looked ideal. Dr. Frank Townsend, who was a previous director, was already chairman of the department at the medical school down in San Antonio. He and I discussed a new program that they were working on down there. Their major teaching hospital was the Audie Murphy Veterans' Hospital, which was looking for a new chairman at that time. The reason that the chairman at the VA was so important was that the school was trying to make that their major teaching hospital, and they were trying to make it transparent to their residents and students, whether they were in the university hospital or whether they

were in the VA hospital. It had already started that the chairman of surgery was at the school; the deputy chairman was over at the VA. The same for medicine: the chairman was at the medical school; the deputy was at the VA. And so Dr. Townsend brought up this proposal to do the same thing with pathology, because they were looking for a new chairman at that time.

I was planning on leaving here to go down there, and hit a period during the history of the VA when they lost their ability to waive my retired pay and pay me their salary at the same time. I did not think that their job was worth what I would be giving up.

While we were trying to wait for them to have this privilege reinstated, things kind of changed down there. The dean got fired, and they told Dr. Townsend that, you know, we've had you on extension, but you really should be emeritus, and we think the time has come. So everything just kind of fell apart.

I spent another six months or so after that looking for something else to take its place. It wasn't until January of '86 that I joined Dr. Black down at Hilton Head. Everybody says, well, you certainly picked a nice place, and I always say that, well, somebody's got to take care of these poor people down there. That's where I was practicing pathology until a year ago, '93. Just day by day, in a nice, little small hospital, in a comfortable environment.

Q: Well, doctor, I want to thank you very much. I really appreciate this.

DR. COWAN: There's probably one other thing that I ought to spend a few minutes on: reaching outside the Institute. While I was here, a couple of things that we got involved in created all kinds of interest.

We always had a program in the Forensic Path. Division, of aircraft accident investigations. We developed quite a bit of notoriety in the services and some other parts of government from what we had done in that section. So when the two 747s ran together over on the Canary Islands in '75, '77, somewhere through there...

Q: It was the worst aircraft disaster ever.

DR. COWAN: Right. We had three hundred and thirteen casualties on the American group, and the Dutch had two hundred and something on theirs. There was a lot of pressure to identify and sort this thing out, so they turned to us and our people there as the nucleus, and added to them some people from the Air Force identification team out at Wright Patterson, and also the FBI, and put a group together. We first went over to Tenerife itself. I didn't get to go on that part of it, but a group of people from here went over there, because we were afraid the Portuguese were going to run the show over there, and we wanted to kind of have a hand in it. But they finally decided it was more than they wanted to bother with, so they agreed to have the bodies embalmed and shipped back to Dover Air Force Base.

Dr. Reals, an Air Force reserve general and a pathologist out in Kansas, has always had an interest in the aircraft program, so he was brought on active duty to head up the group that we took up to Dover to try to investigate this accident and identify all these people. That was the start of sort of working away from the Institute.

Dr. Reals started out, and after a couple of weeks, since I was deputy, he turned it over to me and we finished that one up, and I think did a pretty good job. It was kind of an interesting thing and different, being out in the field and operational rather than having everybody send their stuff in to you.

I was asked, one time, if there was anything humorous up there. And at the time I was asked, I said no. Then I got to thinking about it a little later, and there were a few things that came up. We had also gotten help from the Army mortuary group who keep the records of mortalities and stuff like this down at Fort Bragg. There was a young WAC in the group, and she came up to me one day and said, "You know, I'm the only one that's really equipped to do this job up here. I had a bicycle when I was about 12 years old, and I had base-of-the skull fracture that cut both my olfactory nerves, so I can't smell a thing." And so that was kind of funny.

But it was unbelievable, some of the things that happened in relationships, as you look back. The Portuguese had taken all the jewelry and stuff like this, and we had it lying there on a big table, trying to use it to see if there might be any clues to somebody's identification. We got to thinking one day that maybe we ought to get

somebody from Pan Am to come in and appraise this stuff, to see if it needed to go in a safe somewhere, instead of lying out there on the table. Well, there was one ring, which we thought was paste, but turned out to be diamonds and was appraised at $30,000, lying there on the work table for a couple of weeks. So we took the appropriate steps after that.

We did, I think, about as well as anybody could have done in that. And I think our experience there got us into the next invitation, which was the relationship to Guyana.

Q: Jonestown, the mass suicide.

DR. COWAN: Correct. The Army mortuary group went into the site at Jonestown and transported the bodies down to the nearest large airport, which was Georgetown, Guyana. They then put them on 141s, and again we used Dover as our working site. It was always a joint effort to do what we did, because we had photographers, we had pathologists, we had dental people, and X-ray people. It was just a joint effort. I was sitting there, as everybody was putting the puzzles together to come to identifications and a certain amount of medical investigation that we did in relationship to those. And so we got that one.

And there was one other one that my secretary, Mrs. Kauffman, I think that was probably the most stressful day in her life, because that one was gone, but several years later, there was a crash in Warsaw that killed most of our amateur boxing team. And so there was quite a

bit of pressure being laid on us, even from President Carter's office, to put together a team to go over there and see if we could identify those people. It was kind of nip and tuck as to whether the Polish government would let us or not. And so we were sort of on constant standby. Word finally came to go. In fact, we were having so much trouble with visas that day that we were staying down at National Airport waiting to take a flight out, when the people from our State Department finally pried visas out of the Polish Embassy and brought them down and put them in our hands, so we could actually get in over there. So we had good luck on that time that we had extremely good records, both fingerprints and dental, and were able to identify 29 out of the 30 people that were killed on that accident, which made everybody very happy. But there were so many calls that were coming into my office that day, and I was fending them off as long as I was here, until we left for the airport. And my secretary told me, after I got back, "When you left the office, there were so many demanding people calling, I just hung up the phone and went home!" So that was fun.

We got quite a bit of notoriety here at the Institute out of doing those. Actually, in doing those, I think it was beneficial, leading to another very significant program that grew out of it, in that here at the Institute now there is a medical examiner's office, the equivalent of any large city, that applies to the military services. Some of these aircraft accidents we did made people realize we had the expertise. And then, particularly the pressure from a group

called CAMI, Concerned Parents Against Military Injustice, or something like this, kind of really focused the need for a system like this to deal with military deaths that were overseas. The parents were getting reports back from the commander of the unit that their children were in. They were getting as good information as the commander had to give them, but he didn't have the right information to give them. So it was creating a lot of ill will with the civilian community. That led us to setting up a function here so that all military deaths overseas are sent here for review and coordination, so that the proper information goes out to the families. And I think that has worked very well over the years that it's been in.

Q: Well, doctor, I want to thank you very much. This has been a most illuminating conversation.

DR. COWAN: Well, I've enjoyed chatting with you, too.

Q: Excellent.

DR. COWAN: It's always fun to talk about a period that was interesting in my life.